STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155791	A. BUILDING 00 B. WING	08/24/2012

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: August 20, 21, 22, 23, and 24, 2012 Facility number: 012565 Provider number: 155791 AIM number: 201021970 Survey team: Christine Fodrea, RN, TC Julie Wagoner, RN Tim Long, RN Lora Swanson, RN Census bed type: SNF: 20 SNF/NF: 8 Total: 28 Census payor type: Medicare: 6 Medicaid: 8 Other: 14 Total: 28 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on August	F0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on August 24, 2012. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	29, 2012 by Bev Faulkner, RN			

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F0156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the			

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	individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.			
	Based on record review and interview, facility failed to provide notification of Medicare non coverage in a timely manner for 2 of 3 residents reviewed for Medicare non-coverage. (Resident #17, Resident #2) Findings include: On 8/23/12 at 1:10 P.M., recent notifications of Medicare Non-Coverage letters were requested and reviewed with the Business Office Manager. Three records were reviewed. Resident #2 received a notice of Medicare provider non-coverage on 3/1/12. The effective date coverage was to end was 3/1/12. An interview with Business Office	F0156	F156What corrective action will be accomplished for residents found to have been affected by the alleged deficient practice:Resident 2 and Resident 17 have already ended benefits. Resident 17's notice was timely. Business Office and Social Service staff were promptly inserviced on the procedures for Medicare non-coverage notices.How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective actions will be taken:All residents recieving Medicare benefits are affected by the alleged deficient practice. Business Office and Social Service staff were promptly inserviced on the procedures for Medicare non-coverage notices.What measures will be put into place or what systemic changes will be made to ensure	09/23/2012

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	employee #6 on 8/23/12 at 1:15 P.M., indicated she did not know the residents were to be notified in advance of the date of end of coverage for Medicare. 2. On 8/23/12 at 1:15 P.M., an interview with Business office employee #6 indicated Resident # 17 was discharged to another facility on the day his Medicare benefits were to run out. The Business Office employee #6 indicated the facility did not have a record of notification of the resident's power of attorney regarding when Resident #17's Medicare benefits were to discontinue. 3.1-4(f)(2)		the alleged deficient practice does not recur:During daily stand-up and weekly Medicare meetings any discharges from Medicare coverage will be reviewed by team members. The Business Office Manager / designee attends these meetings and will coordinate the notices of non-coverage. All Medicare residents and/or responsible parties will be given notice of Medicare non-coverage no less than 48 hours of coverage end date. Evidence of this communication will be maintained in each resident's business office file.How the corrective action will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality asurance program will be put into place:All residents whose Medicare coverage ends will be audited monthly by the Businsess Office Support to ensure that non-coverage letters are being distributed timely. The Business Office Support will report to the QAA committee monthly. The results of audit observations will be reported, reveiwed and trended for compliance for a minimum of 6 months - then randomly thereafter for further recommendations.	

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review, and interview, the facility failed to ensure the physician was notified timely of an increase in blood pressure after a fall for 1 of 4 residents reviewed for	F0157	**F 157 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #63 MD was notified of the resident's elevated	09/23/2012

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	accidents. (Resident #63) Finding includes: Interview with the family of Resident #63, conducted on 08/23/12 at 2:30 P.M., indicated the resident had sustained a fall towards the end of June when she had attempted to transfer herself to the bathroom. The clinical record for Resident #63 was reviewed on 08/24/12 at 9:00 A.M. Review of a "Fall Circumstance, Assessment, and Intervention" form, initiated on 06/26/12 indicated the resident was found on the floor of the bathroom on the 400 unit, across from the nurses station. A neurological assessment flow sheet was initiated on 06/26/12 at 6:40 P.M. Review of the neurological form indicated the resident's blood pressure increased from 151/74 on 06/28/12 at 12:00 noon to 202/93 at 4:00 P.M. The nursing progress notes, from 06/27/12 at 4:00 P.M. - 06/28/12 AT 5:30 P.M., indicated a CT scan of the resident's head was requested on 06/27/12 at 1611 (4:11 P.M.) because the resident was "sleepy." On 06/28/11 at 1300 (1:00 P.M.) the		blood pressure on 6/28/12 at 5:00pm per the Change in Condition Form. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: The DHS or designee will review the 24 hour report, circumstance forms and change in condition forms for the last 3 days to ensure that documentation is in place to support that the physician, resident's responsible party and acute care center, if applicable, has been notified timely of a change in condition. In addition, will ensure a response from the MD has been documented.**Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: 1. Physician Notification 2. Change in Condition Form - includes responsible party and acute care center notification.**How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** Per the campus guidelines, the Nursing Leadership Team will review the 24 hour report, circumstance forms and change in condition forms in the daily clinical meeting 5 days a week, ongoing. This	

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	resident's daughter was notified of the physician's order for a CT scan. On 06/28/12 at 5:30 P.M., the nurse's note indicated the resident had experienced a change in condition, as it took three staff to assist the resident off of the toilet. The resident was taken by the family to the hospital for the previously scheduled CT scan. On 06/28/12 at 8:00 P.M., the resident's CT scan results were received and the physician and family were notified. The physician also gave an order to monitor the resident's blood pressure and notify the physician if the systolic blood pressure was above 180. A "Change in Condition Form," initiated on 06/28/12 at 5 P.M., documented the resident's blood pressure of 202/93 and indicated the resident had been unable to stand and required three staff to assist her from the toilet back into her wheelchair. The bottom of the form indicated the resident's family was notified at 06/28/12 at 8:00 P.M., and the physician was notified by phone. The time the physician was notified was not documented specifically on the form.		review is to ensure the Physician, responsible party and acute care center, if applicable, has been notified timely of a change in condition and that a response from the physician has been documented. The Daily Clinical Meeting Report will be completed to document the review of the above stated reports/forms. The following audits and /or observations will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: Daily Clinical Meeting Report review to ensure documented review of change in condition for timely MD, responsible party and acute care center (if applicable) notification and for documented MD response.The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	However, review of the physician orders, indicated on 06/28/12 at 8:00 P.M., an order was received to "Monitor BP if SBP (systolic blood pressure) above 180 update MD." Physician orders received on 08/28/12 at 5:30 P.M., indicated orders were received related to the CT scan. There was no documentation any orders regarding the resident's elevate blood pressure were received prior to 06/28/12 at 8:00 P.M. Interview with the Director of Nursing, on 08/24/12 at 11:15 A.M., indicated because the "Change in Condition" form was initiated on 06/28/12 at 5:00 P.M., the physician notification had occurred at that time. She indicated staff did not always document the notifications or events at the time they had occurred. There was no explanation given as to why the physician did not give orders regarding the resident's blood pressure at the time of the alleged notification. In addition, there was no explanation as to why the family was not notified of the change in condition or the resident's dangerously elevated blood pressure at the time they took her to the hospital for the CT scan. Finally, there was no notification documented to the acute care center			

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	of the resident's dangerously elevated blood pressure when the resident's family brought her in for a scheduled CT scan. 3.1-5(a)(2)			

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F0167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. Based on observation and interview, the facility failed to ensure location of the survey results were adequately displayed. This practice potentially affected all residents. (Resident #6) Findings include: During an interview with Resident #6, a Resident Council representative, conducted on 08/21/12 at 10:00 A.M., it was discovered she did not know the location of the last Department of Health survey results. Observation of the facility lobby, business office hallway, and nursing stations, conducted on 08/21/12 at 10:30 A.M., indicated the survey results were not located and there was no signage disclosing their location. Interview with the Administrator on	F0167	F167What corrective actions will be accomplished for residents found to have been affected by the alleged deficient practice:1) The Administrator promptly placed the appropriate notice in a holder near the survey binder on the receptionist desk.How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions will be taken:1) All residents are affected by the alleged deficient practice:2) The Administrator promptly placed the appropriate notice in a holder near the survey binder on the receptionist desk.What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:1) Notice of location of the survey will results will be included in the admission process for all new residents;2) Reminders will be given to the resident council monthly at their meeting with instructions on how and where to	09/23/2012

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	08/21/12 at 10:35 A.M., indicated the survey results were in a binder on the receptionist's desk but the sign to indicate their location was also in the binder. He indicated he would post the signage so residents and the public knew where to look for the survey results. 3.1-3(b)(1)		access the survey results.How the corrective action will be monitored to ensure the alleged deficient practice will not recur; or what QA program will be put into place:1) The presence of the survey results and the accompanying notice will be audited weekly by the Administrator or designee and reported monthly to the QA committee.	

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and interview, the facility failed to ensure dignity during medication administration for 1 of 11 residents observed receiving medications. (Resident #37) Findings include: On 08/23/12 at 8:45 A.M., Resident #37 was seated in a chair by the ice cream parlor in the hallway. Nurse #10 asked CNA #11 to assist Resident #37 to ambulate to a bathroom across from the nurse's station. CNA #11 and LPN #10 ambulated Resident #37 into the bathroom, left the door open, and assisted the resident to sit fully clothed on the toilet seat in the bathroom while LPN #10 administered medications to her. On 8-23-2012 at 2:03 P.M., the Assistant Director of Nursing (ADON) indicated the resident should have been taken to her room to receive medications and should not have seated her on the toilet.	F0241	**F 241 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Nurse #10 was immediately coached / educated after this alleged deficient practice on the appropriate settings to administer a resident's medication such as the resident's room and why/how administering medications to a resident in a public bathroom, with the door open while he/she is sitting on the toilet seat does not enhance dignity or respect for this resident. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All other residents have the potential to be affected by this alleged deficient practice. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the nursing staff on the following: The standard of dignity and respect of individuality for the residents with a focus on appropriate settings to administer	09/23/2012

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	3.1-3(t)		a resident's medication. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: A med pass observation will be conducted on 3 licensed nurses or QMAs and will focus on / ensure an appropriate setting is selected to administer a resident's medication to maintain the dignity and respect of individuality. The med pass observations will randomly include all 3 shifts. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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BLAIR RIDGE HEALTH CAMPUS	269 MEADOWVIEW DR PERU, IN 46970

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F0279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, interview and record review, the facility failed to initiate care plans identified as necessary through assessment for 1 of 3 residents reviewed for care plans regarding activities of daily living (Resident #6); for 1 of 3 residents reviewed for end of life care plans (Resident #66) and 3 of 10 residents reviewed for care plans regarding psychoactive medications (Resident #25, Resident #80 and Resident #54) Findings include:	F0279	**F 279 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** 1). Resident #6 will be screened by OT to assess for the need of adaptive equipment to improve eating ability. The careplan will be updated based on the resident's need / desire to use adaptive equipment during meal times. 2). Resident #66 is a closed record that was reviewed. 3). Resident #25 care plan initiated for diagnosis of insomnia and related medication use. 4). Resident #54 careplan for psychosocial problem will be	09/23/2012

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	1. Resident #6's record was reviewed 8-23-2012 at 11:03 A.M. Resident #6's diagnoses included but were not limited to high blood pressure, diabetes, and osteoarthritis. In an observation on 8-20-2012 at 12:12 P.M., during the lunch meal, Resident #6 was noted to have difficulty raising her right arm to bring food into her mouth. Resident #6 utilized her left hand to stabilize her grip on the silverware and assist her right arm in an upward motion from her plate in order for her to eat. Resident #6's Minimum Data Set (MDS) assessment indicated she had declined in eating since admission. Resident #6's MDS, dated 03/15/2012, indicated Resident #6 received supervision - oversight, encouragement or cueing to complete eating compared to Resident #6's MDS, dated 6-8-2012, which indicated she received limited assistance. Resident #6 was highly involved in activity; staff provided guided maneuvering of limbs or other non-weight-bearing assistance over the prior 7 days. An admission nurse's note, dated 3-9-12 at 6 P.M., indicated under the nutrition section no adaptive		updated to include diagnosis for dementia with delusions. 5). Resident #80 careplan will be updated to address the resident's anxiety dx and use of Ativan. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: 1). All resident's will be observed in the dining room for any difficulties feeding self. A referral will be made to OT to screen. Any resident requiring adaptive equipment to increase eating ability at meal time will have their careplan updated. 2). Will review the medical record all residents receiving hospice services to ensure there is a careplan in place regarding death or grieving. 3,4,5). Will review the medical record all residents receiving psychoactive medications to ensure a careplan is in place for the use of the medication and the diagnosis related to its use. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Interdisciplinary Care Plan Team on the following: The campus guideline for Interdisciplinary Care Plan. Therapy designee will re-educate the Occupational Therapy staff on documentation guidelines for a Discharge Summary.**How the corrective measures will be**	

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	equipment was being utilized, Resident #6 had no difficulty with swallowing, was eating in the dining room, had loose or broken dentures and no teeth were broken or missing. Interventions on the attached initial care plan included to observe weight per protocol, provide diet per MD order, and observe nutritional labs. The initial nutrition/ hydration care plan, dated 3-9-2012, indicated the reason for Resident #6's nutritional risk included a medical diagnosis, and an infection in her knee replacement. The initial care plan further indicated an individualized care plan was formulated to address the risks, but there was no mention of the ability, inability to feed herself. The quarterly nursing assessment, dated 7-9-2012, indicated Resident #6 was on a planned weight change program and an individualized care plan had been formulated. The assessment did not include any eating concerns. The quarterly assessment completed by nursing on 8-9-2012 indicated no concerns with Resident #6's ability to eat. Current MD orders, dated August		**monitored to ensure the alleged deficient practice does not recur:** Per the campus guidelines, the Nursing Leadership Team will review the 24 hour report, circumstance forms, and change in condition forms and telephone orders in the daily clinical meeting 5 days a week, ongoing. This review is to ensure the careplan have been initiated / updated as necessary through assessment related to use of adaptive equipment during meal time, hospice services and psychoactive medications and related diagnosis. The Daily Clinical Meeting Report will be completed to document the review of the above stated reports/forms. The following audits and /or observations will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: 1). Observation during meal time to ensure adaptive equipment for increasing eating ability is in place for those residents identified. Observe for any residents with difficulties feeding self and complete a referral to OT for a screen. Review the medical record for residents identified as needing adaptive equipment during meal time to ensure careplan is in place. 2). Review the medical record for residents receiving hospice services to ensure a careplan is in place. 3,4,5). Review the medical record	

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	2012, do not include adaptive silverware. A Clinical At Risk (CAR) meeting record, dated 3-23-2012 through 7-6-2012, indicated Resident #6 was on a weight loss diet, but did not address eating difficulties, except the CAR note, dated 5-11-2012, indicated Resident #6 did not have any eating difficulties, and diet was formulated for weight loss. An Occupational Therapy (OT) note, dated 5-25-2012 thru 6-1-2012, indicated OT was reviewing Resident #6's arthritic condition affecting right shoulder, initiating exercises to increase strength in right shoulder and providing adaptive equipment to increase eating ability at meals. On 6-9-2012, an OT note indicated OT was discontinued and Resident #6 was to receive Theraband exercises. There was no note to indicated Resident #6 had been offered adaptive equipment to improve eating ability. A Care plan, dated 03-13-2012, titled nutrition at risk updated 6-5-2012, included multivitamin daily, cottage cheese daily, may take medicines with ice cream, monitor and report		for residents receiving psychoactive medications to ensure a careplan is in place with appropriate diagnosis identified. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	concerns to physician, administer nutritional support, monitor snacks, offer small portions and offer therapeutic diet, weigh and monitor results weekly. The care plan did not include adaptive eating equipment. In an interview on 8-23-2012 at 1:23 p.m., OT #3 indicated Resident #6 had refused adaptive equipment, but it was not documented. He further indicated she did not need a care plan because the nurses would have noted an issue and let therapy know she needed the adaptive equipment. OT #3 further indicated Resident #6 is eating OK now. 2. Resident #66's record was reviewed 8-22-2012 at 2:28 P.M. Resident #66's diagnoses included but were not limited to heart failure, lung cancer, and renal insufficiency. A review of Resident #66's admission nursing assessment revealed Resident #66 was on hospice prior to admission to facility. A review of Resident #66's care plans revealed no care plan in place regarding death or grieving. In an interview on 8-23-2012 at 10:45			

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	A.M., with LPN #5 indicated a care plan for grief and dying should have been initiated. 3. Resident #25's record was reviewed 8-23-2012 at 9:01 a.m. Resident #25's diagnoses included but were not limited to chronic back pain, depression, and insomnia. Resident #25's Minimum Data Set (MDS), dated 8-9-2012, indicated a decreased interest in things around her 2-6 days of the observation period. Resident #25's admission physician orders indicated she was admitted with orders for the following medications: Cymbalta, Trazadone and Lasix. The Trazadone order did not have a stop date indicated, and insomnia was listed as the reason for the Trazadone order. A current care plan, dated 8-4-2012, titled psychosocial problem depression, included interventions of: use strengths and weaknesses, introduce to others, invite to activities, give positive reinforcement, encourage family and friends to remain involved, and monitor the need for psychosocial services.			

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	A current care plan titled depression, dated 8-4-2012, included interventions of monitor for symptoms of depression, report to physician, encourage sharing feelings of loss, encourage participation in activities, encourage socialization, give medicines per physician order, monitor for symptoms of side effects, 1:1 staff visits, encourage visitation by family and friends, and psych consult as needed. A current care plan titled psychotropic drug use related to antidepressant use secondary to depression included the interventions of observe for drug related side effects, report to physician negative outcomes, administer medicines as ordered, educate family on risks/ benefits, observe for effectiveness of medicines, work with physician to provide a therapeutic dosage. There was no care plan regarding insomnia or Trazadone use. In an interview on 8-23-2012 at 9:40 A.M., RN #2 indicated moods and insomnia were discussed in behavior meetings and care plans updated, but behaviors were not being discussed specific to Resident #25 at this time.			

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	She further indicated Resident #25's medications had not been discussed and a care plan regarding insomnia and medications to treat it should have been initiated. A current policy titled Interdisciplinary Care plan guide, dated 01-06 and updated 1-08, indicated a comprehensive care plan would be developed for problem areas relative to concerns, and interventions should reflect the individual's needs and risks. 4. Resident #54's clinical record was reviewed on 8/22/12 at 10:00 A.M. The records indicated the resident was on Risperidone 0.25 milligrams (mg) daily. The resident's physician's orders from 8/1/12 indicated she was receiving the Risperidone 0.25 mg daily for dementia with agitation. The resident's initial psychosocial assessment, dated 4/21/12, indicated the resident had diagnoses including, but not limited to, dementia without behavioral disturbances, depression, anxiety and vascular dementia. The psychosocial assessments, dated 5/5/12 and 6/19/12, indicated the resident had diagnoses including but not limited to, dementia without behavioral disturbances, depression, anxiety and vascular dementia with			

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	delusions. The 5/5/12 assessment indicated the resident was now having delusions. Review of Resident #54's health care plans indicated the resident had a care plan for side effects related to psychotropic medication use dated 3/30/12. Resident #54 also had a care plan for psychosocial problem of actual depression as evidenced by a diagnosis of dementia with behaviors, depressive disorder and anxiety. The resident did not have a health care plan for dementia with delusions. An interview with RN #1 on 8/22/12 at 1:15 P.M., indicated the resident had no health care plan for dementia with delusions. An interview with the Social Service Director (SSD) on 8/23/12 at 10:30 A.M., indicated she did not know the resident had delusions and had no health care plan for dementia with delusions. 5. The clinical record for Resident #80 was reviewed on 08/22/12 at 11:00 A.M. The resident was admitted to the facility on 07/05/12 with diagnoses, including but not limited to: hypertension, dementia, depression, hypercholestremia,			

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	osteoporosis, coronary artery disease, and anxiety. The resident's medication orders, on admission, included the antianxiety medication, Ativan, to be given as needed for anxiety. On 07/08/12, the physician changed the resident's anxiety medication Ativan to a routine medication to be given three times a day. On 08/02/12, the physician was faxed regarding the resident's "anxiousness" in the evening and he increased the resident's Ativan medication to be given four times a day. Review, on 08/22/12 at 1:40 P.M., of the current health careplans for Resident #80 indicated there was a plan to address the resident's "wandering" but no plan to address the resident's anxiety. 3.1-35(a)			

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F0310 SS=D	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. Based on observation, interview and record review, the facility failed to provide assistive eating devices as recommended by therapy for 1 of 3 residents reviewed for assistive devices related to eating. (Resident #6) Findings include: Resident #6's record was reviewed 8-23-2012 at 11:03 A.M. Resident #6's diagnoses included but were not limited to high blood pressure, diabetes, and osteoarthritis. In an observation on 8-20-2012 at 12:12 P.M., during the lunch meal, Resident #6 was noted to have difficulty raising her right arm to bring food into her mouth. Resident #6 utilized her left hand to stabilize her grip on the silverware and assist her right arm in an upward motion from	F0310	**F 310 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #6 will be screened by OT for need of assistive devices / adaptive equipment to improve eating ability. Resident's careplan will be updated to reflect the use or refusal of adaptive equipment by the resident. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents will be observed in the dining room for any difficulties feeding self. A referral will be made to OT to screen. Any resident requiring adaptive equipment to increase eating ability at meal time will have their careplan updated. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Therapy designee will	09/23/2012

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	her plate in order for her to eat. Resident #6 was not observed to have adaptive silverware available for use. Resident #6's Minimum Data Set (MDS) assessment indicated she had declined in eating since admission. Resident #6's MDS, dated 03/15/2012, indicated Resident #6 received supervision - oversight, encouragement or cueing to complete eating compared to Resident #6's MDS, dated 6-8-2012, which indicated she received limited assistance. Resident #6 was highly involved in activity; staff provided guided maneuvering of limbs or other non-weight-bearing assistance over the prior 7 days. The quarterly nursing assessment, dated 7-9-2012, indicated Resident #6 was on a planned weight change program and an individualized care plan had been formulated. The assessment did not include any adaptive equipment related to eating. The quarterly assessment completed by nursing on 8-9-2012 indicated no concerns with Resident #6's ability to eat or her need for adaptive equipment.		re-educate the Occupational Therapy staff on the following guidelines: 1). Occupational Therapy Evaluation and Assessment. 2). Discharge Summary**How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations will be conducted by the Therapy designee 1 times per week times 4 weeks, then monthly times 5 months to ensure compliance: Review of residents documentation who are on caseload for need of adaptive equipment to improve eating ability. Will ensure the documentation includes resident's use or refusal of adaptive equipment to improve eating ability and is reflected in therapy notes and discharge summaries, when applicable. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	Current physician orders dated August 2012 did not include adaptive silverware. A Clinical At Risk (CAR) meeting record, dated 3-23-2012 through 7-6-2012, indicated Resident #6 was on a weight loss diet, but did not address adaptive equipment for eating difficulties. An Occupational Therapy (OT) note, dated 5-25-2012 thru 6-1-2012, indicated OT was reviewing Resident #6's arthritic condition affecting right shoulder, initiating exercises to increase strength in right shoulder and providing adaptive equipment to increase eating ability at meals. On 6-9-2012, an OT note indicated OT was discontinued and Resident #6 was to receive Theraband exercises. There was no note indicating Resident #6 had been offered adaptive equipment to improve eating ability. A Care plan dated 03-13-2012, titled Nutrition at Risk and updated 6-5-2012, included multivitamin daily, cottage cheese daily, may take medicines with ice cream, monitor and report concerns to physician, administer nutritional support, monitor			

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	snacks, offer small portions and offer therapeutic diet, weigh and monitor results weekly. The care plan did not include adaptive eating equipment. In an interview on 8-23-2012 at 1:23 p.m., OT #3 indicated Resident #6 had refused adaptive equipment, but it was not documented. He further indicated she did not need adaptive equipment because the nurses would have noted an issue and let therapy know she needed the adaptive equipment. OTR #3 further indicated Resident #6 was eating OK now. A current policy titled Occupational Therapy Evaluation and Assessment, dated 1-07 and updated 8-2011, indicated treatment interventions were specific treatment activities/ procedures used to remediate problems and achieve goals. 3.1-38(a)(2)(D)			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to implement interventions after a fall to prevent further falls for 1 of 4 residents reviewed who met the criteria for falls (Resident #24) Findings include: Resident #24's record was reviewed 8-22-2012 at 9:23 A.M. Resident #24's diagnoses included but were not limited to chronic lung disease, Parkinson's disease, and arthritis. A nursing fall assessment after a fall on 8-5-2012, dated 8-6-2012, indicated the fall was at 8:10 A.M. No injury was noted. Resident #24 was noted to have tripped on walker wheel while turning a corner. Immediate intervention listed on the assessment indicated one (1) person assist and resident education. A nursing fall assessment after a fall on 8-6-2012, dated 8-7-2012, indicated a fall had occurred at 2 P.M.	F0323	**F 323 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** New interventions were implemented for Resident #24 after each fall on 8/5/12 and 8/6/12, as listed on the fall circumstance forms (nursing fall assessment and immediate intervention). Resident #24 fall care plan was updated to reflect these implemented interventions on the review dates of 8/6/12 and 8/7/12. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: Review of the medical record of residents who have had falls in the past 30 days to ensure interventions have been implemented to prevent further falls and the care plan has been updated with these specified interventions. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Licensed Nurses on the following guideline: Falls	09/23/2012

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	in the library. Resident #24 had been found on the floor without injury. Resident #24 had denied hitting head when he went to sit down and missed his chair. The assessment indicated he had trouble leaning and misjudging when sitting. Neurological checks were completed with no injury indicated. Fall follow-up was completed over 72 hours with no injury indicated. Therapy evaluation was the immediate intervention listed on the fall assessment. Initial nursing assessment, dated 7-24-12 at 5 P.M., indicated Resident #24 was not at risk for fall despite mobility impairment, and past history of falls. Care plans initiated on 7-24-2012, titled safety indicated interventions were to assess fall risk quarterly and as needed, provide assistive device and ensure it is accessible, provide assistance for transfers and ambulation as needed, provide clear directions and ensure understanding, ensure glasses are clean and in place, refer to therapy, ensure call light is in reach, and provide 1/2 rails for bed mobility. A sensory care plan, initiated 7-24-2012, included to face resident		Management Program. Therapy Designee will re-educate the Physical Therapy staff on guidelines for documenting / updating plan of care to reflect fall prevention of a resident on caseload who has experienced a fall. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** Per the campus guidelines, the Nursing Leadership Team will review the 24 hour report, circumstance forms and change in condition forms in the daily clinical meeting 5 days a week, ongoing. This review is to ensure that a new intervention has been implemented post fall and the careplan has been updated. The Daily Clinical Meeting Report will be completed to document the review of the above stated reports/forms. In addition, Nursing will complete a Nursing to Therapy Communication form to notify therapy of a residents fall. The following audits and /or observations will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: Review of 3 falls to ensure the intervention(s) have been implemented and the careplan has been updated to prevent further falls. Therapy designee will review the plan of care of 3 residents on caseload that has experienced a fall to ensure it has been updated	

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	and speak slowly, ensure hearing aids were in proper working order, ensure glasses were clean and in place, and encourage to stay awake during day. A mobility plan of care, initiated 7-24-2012, indicated to have staff assistance of one as needed with transfer and activities of daily living, ensure assistive device is available and in reach, observe for decline or improvement in weight bearing, encourage mobility as able, and encourage to use call light. Care plan for falls, dated 7-31-2012, indicated Resident #24 was at risk for falls due to Parkinson's disease, abnormal gait, antidepressant use, and use of wheeled walker. Interventions included use of fall risk assessment, to monitor for medication side effects, report to physician any negative side effects, use 1/2 side rails as enables, ensure call light is in reach, ensure area was free of clutter, provide wheeled walker for use, assure appropriate footwear, encourage activity programs, referral to therapy, and provide resident teaching. No additional interventions were noted to be put into place after falls on 8-5-2012 and 8-6-2012.		1 tiime per week times 4 weeks, then monthly times 5 months.The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	In an observation 8-22-2012 at 10:25 AM, Resident #25 was observed in room , sleeping in lounge chair, wheeled walker in front of him, call light in reach. Physical therapy (PT) notes indicated therapy had been initiated on 7-25-2012 with a goal to improve gait and balance. Rest breaks were necessary during walking to apartment on Assisted Living was indicated in the therapy notes, dated 8-14-2012 and 8-21-2012, but plan of care for fall prevention had not been updated. In an interview on 8-22-2012 at 10:47 A.M., the ADON indicated fall prevention interventions should have been updated after each fall. He further indicated therapy had reviewed Resident #24 after falls and found no issue with balance, although therapy was monitoring the balance issue. A current policy titled Falls Management Program Guidelines, dated 1-06 and revised 3-08, indicated should the resident experience a fall, the nurse should complete the circumstance form and include interventions to reduce risk of a repeat episode			

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	3.1-45(a)(2)			

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F0325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on interview and record review, the facility failed to assess weight loss and follow Registered Dietician recommendations to prevent weight loss for 1 of 3 residents reviewed with weight loss (Resident #77) Findings include: Resident #77's record was reviewed 8-22-2012 at 1:03 P.M. Resident #77's diagnoses included but were not limited to GERD (reflux), adult failure to thrive, and diabetes. Resident #77's weights were as follows: Weight on 6-30-2012 : 217 Weight on 7-1-2012: 213 (which was 4 lbs less than 6-30-2012, or a 1.8 % loss) Weight on 7-8-2012: 212 (which was 5 lbs less then 6-30-2012, or a 2.3%	F0325	**F 325** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #77 was a closed record review. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: 1). Will review the current weight status of current residents and add to the Clinically at Risk (CAR) assessment review, if applicable and careplan has been updated. 2). Will review any current significant weight loss/gain to ensure it is documented that the MD was notified and careplan has been updated. 3). Will also review the last RD progress notes in each medical record of current residents to ensure any recommendations listed were	09/23/2012

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	loss) Weight on 7-15-2012: 204 (which was 13 lbs. less than 6-30-2012, or a 6.0% loss) Weight on 7-22-2012: 187 (which was 30 lbs less than 6-30-2012, or a 13.8% loss) Weight on 7-29-2012: 178 (which was 39 lbs. less than 6-30-2012, or a 18.0% loss) A vital sign and weight record entry, dated 7-22-2012, indicated physician, family and dietary were notified of loss occurring 7-22-2012, but no note was included on the entry for 7-15-2012. A 7-6-2012 Clinical At Risk (CAR) meeting note indicated Resident #77 was lethargic, and blood sugars were unstable; but there was no indication of weight loss from 7-1-2012 of 4 lbs, which indicated the initial loss. The 7-13-2012 CAR note indicated the facility had added fortified milk, at lunch and dinner with reference to the weight taken 7-8-2012 of 211.6. The 7-20-2012 CAR note indicated weight was 204.4 and Resident #77 was to be seen by the dietician, but neither the physician nor family was notified. No further interventions were noted on the 7-20-2012 CAR record; however, there was a directive to see		implemented and careplan has been updated. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Nursing Leadership Team and the RD on the following guidelines: Clinically at Risk (CAR) Program, High Risk Nutrition, and Weight Tracking. In addition, will review with the RD regarding accuracy of transcribing recommendations from the progress notes to the recommendation summary form, which is used for nursing to follow up with MDs. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** Per the campus guidelines, the Nursing Leadership Team will review significant weight report in the daily clinical meeting 5 days a week, ongoing. This review is to ensure there are an assessment review (thru the CAR program), MD / RD notification, recommendations implemented and careplan updated. The Daily Clinical Meeting Report will be completed to document the review of the above stated reports (identified as MDSI widget review). The following audits and /or observations will be conducted by	

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	the dietician notes. There was no dietician note to correspond with the 7-20-2012 date. The CAR note on 7-27-2012 indicated Resident #77's weight was 187 and appetite was poor. 2 cal (supplement), 120 cc's was added three times daily between meals. The 8-3-2012 CAR note indicated Resident #77's weight was 178 and the Nurse Practitioner had ordered hospice. The note further indicated Resident #77 was refusing to eat most meals, but no interventions were noted except Resident #77 liked fortified milk and would sometimes drink 2 glasses. The Nurse Practitioner noted to add the diagnosis of failure to thrive on 8-3-2012. Nutritional notes, dated 7-5-2012, indicated Resident #77 was at risk for weight fluctuations due to edema and diuretic therapy,the note further indicated Resident #77 may need fortified milk at lunch and dinner, the staff would monitor for the need and Resident #77 would be followed per protocol and as necessary. The next nutritional notes to appear were dated 7-24-2012. The notes were written by the Registered Dietician (RD) which referred to the weight of 179.4 and the significant		the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: 1, 2, 3). Review 3 resident identified with a significant weight loss/gain to ensure the following: there is an assessment review (thru the CAR program), documentation that the MD has been notified of the loss/gain, the careplan has been updated and the RD progress notes documentating recommendations were transcribed to the recommendation summary form and followed up on with the MD and careplan updated. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	weight loss in a week, 179.4 from 204.4. The RD noted this was a significant loss of 12.3% and requested a reweigh. She noted edema had reduced some, which could account for some weight loss, and resident eats Controlled Carbohydrate diet independently in the dining room without difficulty regarding chewing- swallowing. Fortified milk was being offered at lunch and dinner since 7-5-12 and will follow up with reweigh. A further dietician note, dated 7-242012, indicated the dietician had noted Resident #77's weight loss and the reweigh was 187. Resident #77 had lost 29 lbs (13.5%) since June 30th, about 30 days ago, and the loss was significant. Some initial weight loss could be contributed to fluid imbalance, and resident not eating well at all. Recommend fortified milk at each meal and 120 ml, 2 cal supplement between meals three times per day to aid in weight stabilization and to follow as necessary. A care plan, dated 7-9-2012, titled edema indicated Resident #77 had heart failure. Interventions included observe for edema or fluid overload, respiratory difficulty, increased			

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	swelling, or change in vital signs, report significant assessment data to physician, administer/ observe treatment effectiveness, administer medicines as ordered, and observe effectiveness, provide frequent rest periods, observe labs as ordered and report abnormal results to physician, provide resident and responsible party with education regarding diet and fluid needs and disease processes and observe edematous areas for skin changes. A care plan titled failure to thrive dated 7-9-2012 included interventions of see nutrition care plan, provide fluids as tolerated, supplements per order, assist with diagnostic testing per order, medicines and treatments per order. The care plan did not include a potential for weight loss. A care plan titled renal insufficiency, dated 7-9-2012, indicated to discuss condition and concerns with resident / family, therapeutic diet as ordered, encourage consumption of foods/ fluids to meet requirements, observe weight protocol, and provide resident education. A nutrition care plan, dated 7-5-12, indicated Resident #77 was at risk for significant weight gain related to high			

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	blood pressure, GERD, heart failure, and failure to thrive. Interventions included monitor and report to physician signs or symptoms malnutrition, significant weight loss, chewing, swallowing problems, administer nutritional support as ordered, vitamin supplements, provide and monitor intake of diet/ fluids, offer snacks, therapeutic diet as ordered, weigh and monitor results weekly, and updated 7-6-12 fortified milk at lunch and dinner and updated 7-25-12, 2 cal three times per day between meals. A current physicians order summary, dated August 2012, did not include the recommendation to increase the fortified milk to three times daily. Further review of the physician's orders revealed on order and clarification for 2 cal supplement three times per day on 7-25-2012, but no other nutritional intervention was ordered. In an interview on 8-23-2012 at 1:15 P.M., the Assistant Director of Nursing (ADON) indicated the dietician had not reviewed Resident #77 on her regular visit on 7-17-2012, but did not know why. The ADON further indicated the dietician had not noted her recommendation for			

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	fortified milk at each meal on her recommendation communications to the facility, so the recommendations were not followed. A current policy titled High Risk Nutrition, dated 12-07, indicated criteria was a significant loss of 55 within 30 days, and significant change in appetite. Guidelines included Residents experiencing weight loss are to be assessed to determine possible causes and to provide fortified foods and preference of food choices. 3.1-46(a)(2)			

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on observation, interview and record review, the facility failed to adequately monitor for psychotropic medication use for 2 of 10 residents reviewed for medication use (Resident # 54 and Resident #25). The facility further failed to attempt non-pharmacological interventions prior to administration and with no indication for use of antianxiety for 1 of 10 residents reviewed for psychoactive medication use (Resident #80).	F0329	**F 329** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** 1). Resident #25 care plan initiated addressing the insomnia diagnosis and need for monitoring insomnia and related medication use. 2). Resident #54 care plan initiated addressing the dementia with delusions or agitation diagnosis. 3). Resident #80 care plan was initiated to address the resident's anxiety,	09/23/2012

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	Findings include: 1. Resident #25's record was reviewed 8-23-2012 at 9:01 A.M. Resident #25's diagnoses included but were not limited to dementia, depression, and insomnia. Resident # 25's admission orders included an order for Trazadone 50 milligrams (mg) at bedtime. The Trazadone order did not have a stop date on admission. Insomnia was listed as diagnosis for Trazadone use. In an interview 8-23-2012 at 9:40 a.m., RN #2 indicated moods and insomnia are discussed in behavior meetings, but Resident #25 is not discussed in behavior meeting at this time and medications have not been reviewed for appropriate use or gradual dose reduction. RN #2 further indicated the pharmacist comes in monthly and reviews medications, then the facility discusses and reviews recommendations with the physician. RN #2 indicated there was no other monitoring other than the behavior meeting. There was no care plan addressing insomnia or the need for monitoring		adjustment to the campus and related medication use. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: Will review the medical record all residents receiving psychoactive medications to ensure a careplan is in place for the use of the medication and the diagnosis related to its use. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Interdisciplinary Care Plan Team on the following: The campus guideline for Interdisciplinary Care Plan. DHS or designee will re-educate the Licensed Nurses on the following related to non-pharmacological interventions prior to use of psychoactive medications: 1). Administration of PRN Medications Guideline 2). Mental Health Wellness Treatment Planning.**How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** Per the campus guidelines, the Nursing Leadership Team will review the 24 hour report, circumstance	

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	insomnia or Trazadone. A current policy titled Medication Monitoring and Management, dated 2-1-2010, indicated the resident's medication regimen would be evaluated with admission, periodically, to determine if a medication is indicated. 2. Resident #54's clinical records were reviewed on 8/22/12 at 10:00 A.M. The records indicated the resident was on Risperidone 0.25 milligrams (mg) daily. The resident's physician's orders from 8/1/12 indicated she was receiving the Risperidone 0.25 mg daily for dementia with agitation. The resident's initial psychosocial assessment, dated 4/21/12, indicated the resident had diagnoses including, but not limited to, dementia without behavioral disturbances, depression, anxiety and vascular dementia. The resident's initial psychosocial assessment, dated 5/5/12, indicated the resident had diagnoses including, but not limited to, dementia without behavioral disturbances's, depression, anxiety, and vascular dementia with delusions. The resident's initial psychosocial assessment, dated 6/19/12, indicated the resident had diagnoses including,		forms, telephone orders and change in condition forms in the daily clinical meeting 5 days a week, ongoing. This review is to ensure the careplan have been initiated / updated as necessary to provide adequate monitoring of psychotropic medication use and related diagnosis. In addition, thru the daily clinical meeting, the monitoring of documented non-pharmacological interventions prior to psychotropic administration will be reviewed. The Daily Clinical Meeting Report will be completed to document the review of the above stated reports/forms. The following audits and /or observations will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: 1). Review the medical record for residents receiving psychotropic medication to ensure a careplan is in place with appropriate diagnosis identified provide adequate monitoring for its use. 2). Review the use of PRN or new / changed orders for a psychotropic medication to ensure documentation is in place to support the attempts of non-pharmacological interventions prior to administration. The results of the audit observations will be reported,	

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	but not limited to, dementia without behavioral disturbances, depression, anxiety and vascular dementia with delusions. Review of Resident #54's health care plans indicated the resident had a care plan for side effects related to psychotropic medication use dated 3/30/12. Resident #54 also had a care plan for psychosocial problem of actual depression as evidenced by diagnoses of dementia with behaviors, depressive disorder and anxiety. The resident did not have a health care plan for dementia with delusions or agitation. An interview with RN #1 on 8/22/12 at 1:15 P.M., indicated the resident had no health care plan for dementia with delusions or agitation. RN #1 indicated CNA's did monitoring of watching for lethargic behaviors and notify nurse and monitor for suspicious thoughts and notify nurse. An interview with the Social Service Director (SSD) on 8/23/12 at 10:30 A.M., she indicated she did not know the resident had delusions and had no health care plan for dementia with delusions or agitation. The SSD did not know of any monitoring of delusions or agitation done for		reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	Resident #54 as she had no idea of Resident #54 having delusions or agitation. 3. The clinical record for Resident #80 was reviewed on 08/22/12 at 11:00 A.M. The resident was admitted to the facility on 07/05/12 with diagnoses, including but not limited to: hypertension, dementia, depression, hypercholesteremia, osteoporosis, coronary artery disease, and anxiety. The resident's medication orders, on admission, included the antianxiety medication, Ativan, to be given as needed for anxiety. On 07/08/12, the physician changed the resident's anxiety medication Ativan to a routine medication to be given three times a day. Nurse's notes, from 07/05/12 - 07/08/12, did not indicate any issues with behaviors. The admission nursing assessment, completed on 07/05/12 at 5:30 P.M. for Resident #80 indicated both the resident and her daughter were "tearful" regarding the resident's placement at the long term care facility. Daily nursing skilled assessments for 07/07/12 and 07/08/12 indicated the			

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	resident was not coming to the dining room for meals and had called her daughter late at night. Interview with ADON, on 08/22/12 at 1:30 P.M., indicated other than faxed communication with physician he could not locate any documentation from 07/05/12 - 07/08/12 except documentation that the resident was calling her daughter frequently. Review of the 07/08/12 fax to the physician indicated "resident is very anxious at times and continually states she is going home. Daughter wants to know if there is anything you can give her to calm her and help the process of getting used to living here. (sic)." The physician ordered Ativan. The daily health nursing shift to shift reports for 07/07/12 and 07/08/12 indicated the resident's daughter wanted the telephone unplugged after 8:00 P.M., and was requesting the physician give the resident something to calm her as the resident "wanted to go home." On 08/02/12, the physician was faxed regarding the resident's "anxiousness" in the evening and he increased the resident's Ativan medication to be given four times a			

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	day. There was no documentation the facility attempted non-pharmacological interventions prior to obtaining an order for the antianxiety medication. In addition, although the resident had a care plan for "wandering" there was no plan to address the resident's "anxiety" and adjustment to the facility. 3.1-48 (a)(3) 3.1-48 (a)(4)			

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F0371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, and interview, the facility failed to ensure food was prepared in a sanitary condition for 1 of 2 kitchens in the facility. In addition, the facility failed to ensure staff handled food properly in 1 of 1 dining rooms observed. This potentially affected 20 of 28 residents in the facility who consumed food from the healthcare kitchen. Finding includes: During the kitchen sanitation tour of the healthcare kitchen, conducted on 08/20/12 at 10:15 A.M., the ceiling vent above an upright refrigerator and bread cart, with unopened loaves of bread, was noted to be laden with dust. On 08/20/12 at 12:10 P.M., Cook #1 was observed serving meal trays from the steam table located in the main dining room. The cook was noted to have washed her hands, donned a pair of disposable gloves, and	F0371	F371What corrective actions will be accomplished for the residents found to have been affected by the alleged deficient practice:1) Inservice will be conducted for all dietary employees on proper procedure for handling ready to eat foods in regard to glove wearing and contamination.2) The vent in question was promptly cleaned by the Mainteance staff.How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions will be taken:1) All residents have the potential to be affected by the alleged deficient practice.2) Inservice will be conducted for all dietary employees on proper procedures for handling ready to eat foods in regards to glove wearing and contamination.3) The vent in question was promptly cleaned by the Maintenance staff.What measures will be put into place or what systemic systems changes will be made to ensure the alleged deficient practice does not recur:1) The DFS (Director of Food Service) or designee will	09/23/2012

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	handled paper menus with both gloved hands, then touched hamburger buns and tomato slices directly with her gloved hands. In an interview on 8-21-2012 at 10:45 A.M., Cook #1 indicated the vents were cleaned periodically, but could not say when the vents had been cleaned last. 3.1-21(i)(3)		document observations of food handling technique by line staff 5 x per week and take corrective action as needed. Observations will be documented on a log.2) The Maintenance staff will make a weekly check of vents in the Dietary department and coordinate cleaning as needed. Checks will be documented on a log.How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:Results of the food handling audits and the vent cleaning audits will be reported to the QAA committee monthly by the DFS and Maintenance Director respectively. The results will be reviewed and trended for compliance through the campus QAA committee for a minimum of 6 months then randomly thereafter for further recommendations.	

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F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation and record review, the facility failed to ensure	F0441	**F 441**	09/23/2012

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	infection control standards were observed by 1 of 3 nurses during med pass. This affected 2 of 11 residents observed for medication pass procedures. (Residents #71 and # 35). Findings include: 1. While waiting to watch medication administration pass, on 08/23/12 at 8:30 A.M., LPN #10 was observed preparing medication for Resident #71. The LPN was noted to repeatedly pop medication from the blister packaging into her hand and then placed the medications into a medication cup. The LPN had handled the medication packaging, keys to the cart, the cart buttons, water pitchers, and the Medication Administration Record book with her hands while intermittently placing the pills in her hands. ON 08/23/12 at 8:40 A.M., LPN #10 was observed preparing the medications for Resident #35. LPN #10 was noted to have touched medication packaging cards and the cart buttons. LPN #10 then picked an antacid tablet out of the medication cup and manually placed the pill in a bag to crush the medication.		**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Nurse #10 was immediately coached / educated after this alleged deficient practice regarding the requirement of washing hands with soap and water or alcohol gel prior to handling tablets, according to the Medication Administration General Guidelines. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents have the potential to be affected by the same alleged deficient practice. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Licensed Nurses and QMAs on the following: The campus guideline for Medication Administration - General Guidelines, with focus on the section of breaking tablets and hand washing. Will apply that, following infection control standards, when handling oral tablet medications, one must wash hands with soap and water	

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	Review of the facility policy and procedure, titled, "Preparation and General Guidelines, " dated 02/01/10, and indicated as current on 08/24/12 by the Director of Nursing, indicated there were no specific instructions regarding not handling the pills directly. 3.1-18(b)		or use alcohol gel prior to. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: A med pass observation will be conducted on 3 licensed nurses or QMAs and will focus on / ensure infection control standards are observed. Will observe for hand washing / use of alcohol gel if there is a need to handle oral/tablet medications. The med pass observations will randomly include all 3 shifts The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	